Risk Matters: What to Keep Out of the Medical Record

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At SVMIC, we stress the importance of accurate and timely documentation and for good reason – in the event of a claim or lawsuit, the medical record will be the most important piece of physical evidence. But, just as important as what to include in the medical record is what **not** to include.

Only clinically pertinent patient-care-related information should be entered in the patient's medical record. Documents that do not constitute the official medical record should be kept separate from the medical record and restricted from disclosure. Examples include incident reports, privileged documents, and correspondence with SVMIC.

Most communications with your attorney are legally privileged and, as such, are not subject to discovery. Similarly, communications with SVMIC relating to a lawsuit, claim, or even a potential claim may also be privileged. These communications should be kept separate

from the patient's chart, thereby eliminating the possibility of being photocopied or provided to the opposing party without a court order specifically compelling their production.

The record should contain only facts and objective clinical judgment. Remarks on a patient's personal characteristics are not appropriate. Examples of terms or phrases not to use in the record include "Drug-seeking," "Drunk," and "Liar/lying." Finally, billing records and peer review documents should also be kept out of the medical record.
